Adult Member Health Record

ABOUT YOU

Name:

Mailing Address:

City: State/Zip

Phone:

Email Address:

Date of Birth: Age:

Social Security Number:

Marital Status: Number of Children

Employer Name:

Employer Address:

Employer City: *Employer State/Zip*

Work Phone: *Position Title:*

Payment Method: *Cash* ☐ *Check* ☐ *Credit Card* ☐

ABOUT YOUR SIGNIFICANT OTHER

Name:

Phone:

ANOTHER EMERGENCY CONTACT

Name:

Phone: Relation:

HEALTH HABITS

Do You Smoke? ☐ Yes ☐ No If Yes, how much per day _____.

Do You Drink Alcohol? ☐ Yes ☐ No If Yes, how much per day_____.

Do You Drink Coffee, Tea, or Soda? ☐ Yes ☐ No If Yes, how much per day_____.

Do You Exercise Regularly? ☐ Yes ☐ No

CHIROPRACTIC EXPERIENCE

Who Referred You To Our Office?

Have You Been Adjusted By A Chiropractor Before?

If Yes, What Was The Reason For Those Visits?

Doctor's Name:

Approximate Date Of Last Visit:

Reason For This Visit

Describe The Reason For This Visit:

Is The Purpose Of This Appointment Related To:
☐ Job ☐ Sports ☐ Auto ☐ Fall
☐ Chronic Discomfort ☐ Other

Please Explain:

When Did This Condition Begin?

Has This Condition:
☐ Gotten Worse ☐ Stayed The Same ☐ Come & Go

Does This Condition Interfere With:
☐ Work ☐ Sleep ☐ Daily Routine

Please Explain:

Has This Condition Occurred Before? ☐ Yes ☐ No
Please Explain:

Have You Seen Other Doctors For This Condition?
☐ Yes ☐ No

Doctors Name:

Type Of Treatment:

Results:

WERE YOU AWARE THAT...

Doctors of Chiropractic Work With The Nervous System? ☐ YES ☐ NO

The Nervous System Controls All Bodily Functions and Systems? ☐ YES ☐ NO

Chiropractic Is The Largest Natural Healing Profession In The World? ☐ YES ☐ NO

GOALS FOR YOUR CARE

People see Chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others for correction of whatever is malfunctioning in their body. Your Doctor will weight your needs and desires when recommending your care program. Please check the type of care desired so that we may be guided by your wishes whenever possible.

☐ **Patch Care:** Symptomatic relief of pain or discomfort

☐ **Corrective Care:** Correcting and relieving the cause of the problem as well as the symptom.

☐ **Optimal Wellness Care:** Bring whatever is malfunctioning in the body to the highest state of health possible with Chiropractic Care.

MEDICATIONS YOU TAKE

☐ Cholesterol Meds	☐ Blood Pressure Meds
☐ Stimulants	☐ Blood Thinners
☐ Tranquilizers	☐ Pain Killers
☐ Muscle Relaxers	☐ Vitamins:
☐ Insulin	☐ Supplements:

YOUR CONCERNS

INSTRUCTIONS: *Please* ***circle*** *the health concerns or conditions you may be experiencing now or have in the past. Each area of concern relates to an area of the spine and nerve function.*

Oc, C1, C2, C3, C4
Headaches
Migraines
Dizziness
Sinus Problems
Allergies
Fatigue
Head Colds
Vision Problems
Difficulty Concentrating
Hearing Problems

C5, C6, C7, T1
Sore Throat
Stiff Neck
Radiating Arm Pain
Hand Numbness
Asthma
Allergies
High Blood Pressure
Heart Conditions

T2, T3, T4, T5, T6, T7, T8, T9
Mid Back Pain
Congestion
Difficult Breathing
Bronchitis
Pneumonia
Gallbladder Issues
Stomach Problems
Ulcers / Gastritis
Kidney Problems

T10, T11, T12

L1, L2, L3, L4, L5, S, A, C, R, A, L
Constipation
Colitis
Diarrhea
Gas Pain
Irritable Bowel
Bladder Problems
Menstrual Problems
Low Back Pain
Leg Pain
Leg Numbness
Reproductive Issues

HEALTH CONDITIONS

INSTRUCTIONS: Please check each of the diseases or conditions that you now have or have had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis, care plan and the possibility of being accepted for care.

☐ Severe or Frequent Headaches	☐ Thyroid Problems	☐ Pain in Arms/ Legs Or Hands	☐ Numbness	FOR WOMEN ONLY (Please Circle One)
☐ Heart /Pacemaker	☐ Sinus Problems	☐ Low Blood Pressure	☐ Allergies	Pregnancy: YES NO
☐ Lower Back Problems	☐ Hepatitis	☐ Diabetes	☐ Difficulty Breathing	Are You Nursing? YES NO
☐ Digestive Problems	☐ Kidney Problems	☐ Ulcers / Colitis	☐ Surgeries	Are you taking Birth Control? YES NO
☐ Pain Between Shoulders	☐ Asthma	☐ High Blood Pressure	☐ Loss of Sleep	Experience Painful Periods? YES NO
☐ Congenital Heart Defect	☐ Arthritis	☐ Chemotherapy	☐ Shingles	Have Irregular Cycles? YES NO
☐ Frequent Neck Pain	☐ Dizziness	☐ Stroke	☐ Cancer	Have Breast Implants? YES NO

AUTHORIZATION FOR CARE

I hereby authorize the Doctors to work with my condition through the use of adjustments to my spine, as they deem appropriate. I clearly understand and agree that all services rendered me that are not covered under my insurance are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. The Doctors will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will become immediately due and payable.

Signature:	Print:
Guardian or Spouse Authorizing Care Signature:	Date:

How will you be taking care of your services today?

☐ CASH ☐ CHECK ☐ CREDIT CARD

TERMS OF ACCEPTANCE

When a patient seeks chiropractic care and we accept such a patient for care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is only when the patient understands both the objective and the method that they will be able to attain it. This will prevent any confusion or disappointment.

An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments to the spine.

Health is a state of optimal physical, mental and social well being, not merely the absence of disease.

Vertebral Subluxation is a misalignment of one or more of the joints of the body. This can cause pain or alteration of nerve function and interference of the transmission of nerve impulses, lessening the body's innate ability to maintain maximum health.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area. Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxation.

I have read and fully understand the above statement. Any questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

Signature:	Print:
Guardian or Spouse Authorizing Care Signature:	Date:

NOTICE OF PRIVACY POLICY

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent.

- You may request restrictions on your disclosures.
- You may inspect and receive copies of your records within 30 days with a request.
- You may request to view changes to your records.
- In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and its staff via text alerts and/or emails.

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- ***Conduct, plan and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly.***
- ***Obtain payment from third party payers.***
- ***Conduct normal healthcare operations such as quality assessments and physician's certifications.***

I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and or disclosed.

PATIENT NAME (PLEASE PRINT):	RELATIONSHIP TO PATIENT:
SIGNATURE:	DATE:

ANY OTHER INFORMATION YOU THINK MIGHT HELPT THE DOCTORS